



HUMAN RESOURCES
& DEVELOPMENT
TULARE COUNTY

VERIFICATION OF PROOF OF OTHER COVERAGE PLAN YEAR 2016

- I have elected to waive the County's health insurance coverage for Plan Year 2016.
- I understand that I am required to provide written verification that will validate my coverage under another qualifying plan for Plan Year 2016. **Failure to provide such verification will result in the forfeiture of my Benefit Amount.**
- I understand that I am required to report ANY changes in my other coverage status within 30 days of the event date for Plan Year 2016 to HR&D - Benefits.

Please fill-in information below:

Employee Name:		EE ID #:
Insured / Subscriber Name:		
Relationship to Insured/Subscriber: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENTS <input type="checkbox"/> Other: _____		
Employer/Group Name:		
Insurance Carrier Name:		
Effective Date:	Group #:	ID#
Plan Type: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> EPO <input type="checkbox"/> Other: _____		Tier Level: <input type="checkbox"/> EE Only <input type="checkbox"/> EE + 1 <input type="checkbox"/> Family
I am covered as:		<input type="checkbox"/> Primary <input type="checkbox"/> Dependant

Acceptable forms eligible for Proof of other Coverage (Please select the type of documentation provided*):

- ☐ Health Insurance Identification card
- ☐ Statement from another employer: On company letterhead that includes verification of coverage levels and dates of coverage.
- ☐ Certificate of Creditable Coverage: Distributed by the carrier upon enrollment in the plan; also known as a HIPPA Certificate.
- ☐ COBRA General Notice: Must list names of the dependents that are covered.
- ☐ Medi-Cal – Current Notice of Action for Medi-Cal recipients

***Attach a copy of the proof listed above.**

By signing this form, I acknowledge that the above is true and accurate.

Signature: _____ Date: _____

Submit this information to HR&D Benefits.
Send via Fax to 559-730-2597; Scan and Email to www.OEHealth@co.tulare.ca.us; or
Mail to HR&D – Benefits Unit at 2900 W. Burrel Avenue, Visalia, CA 93291